BENEFIT CHOICE OPTIONS PERIOD 2

October 27 – November 14, 2008

(Effective January 1, 2009 – June 30, 2009)

SECTION A: EMPLOYEE INFORMATION (required)

SSN: ___ ___

Last Name	First Name	Phone Numbers	
		Home:	Work:

SECTION B: OPT OUT / OPT IN

OPT OUT/OPT IN – If you elect to opt out, Health, Dental, Vision and Prescription coverage for you and your dependents will be terminated		
☐ Opt Out	☐ Opt In	**See Section B on the back for requirements**

SECTION C: HEALTH PLAN ELECTIONS (complete ONLY IF CHANGING your health plan)

Health Plan Election *	**If you selected Managed Care, you must complete the information below. Go to the health plan's website to find the provider identifier.** See the instructions on back for more information.
Elect One:	Provider Identifier _____ (6 or 10 characters)
Quality Care Health Plan (QCHP) ☐	Carrier Code _____ (2 characters – see page 13)
~ Or ~	Plan Name _____
Managed Care (HMO or OAP) ☐	

* You must complete a Coordination of Benefits Worksheet for yourself and/or any dependent that has other insurance coverage (including Medicare or Medicaid). The Coordination of Benefits Worksheet is available at www.benefitschoice.il.gov.

SECTION D: DENTAL PLAN OPTION (complete ONLY IF CHANGING your dental election)

Dental Plan Option – If you elect not to participate in the Dental plan, your Dental coverage (and dependent dental coverage) will be terminated (Health, Vision and Prescription coverage will remain active)	
☐ I choose not to participate in the dental plan	☐ I choose to enroll/re-enroll in the dental plan

SECTION E: OPTIONAL LIFE INSURANCE (complete ONLY IF CHANGING your life coverage elections)

OPTIONAL LIFE Member Paid	☐ INCREASE [2]	☐ DECREASE	☐ CANCEL	**AD&D (Accidental Death & Dismemberment)** Member Paid	
☐ 1 x Salary	☐ 3 x Salary	☐ 5 x Salary	☐ 7 x Salary	☐ CANCEL AD&D	☐ BASIC only (Equal to Salary)
☐ 2 x Salary	☐ 4 x Salary	☐ 6 x Salary	☐ 8 x Salary		☐ COMBINED (Basic + Optional Life)

SECTION F: DEPENDENT INFORMATION [1] (dependents will be enrolled in the same health plan as the member)

HEALTH A (Add) / D (Drop) / C (Change)			LIFE [2]		Name	SSN	Birth Date	Relationship[3]	Sex (M/F)	Provider Identifier
A	D	C	A	D						
☐	☐	☐	☐	☐						
☐	☐	☐	☐	☐						
☐	☐	☐	☐	☐						
☐	☐	☐	☐	☐						

Notes: [1] Documentation required to add dependents – see specific documentation requirements on the back.

[2] Statement of Health form required when increasing Optional Life or adding Spouse or Child Life (form on page 33). Mail completed form to: ***Minnesota Life, 1 North Old Capitol Plaza, Suite 305, Springfield, IL 62701***.

[3] Relationship must be spouse, son, daughter, stepchild, adopted child, adjudicated child or legal guardian.

I authorize prevailing premiums to be deducted from my pay or annuity for those plans I have selected. This authorization will remain in effect until I provide written notice to the contrary. The information contained in this form is complete and true. I agree to abide by all Group Insurance Program rules. I agree to furnish additional information requested for enrollment or administration of the plan I have elected.

MEMBER SIGNATURE: _____ DATE: _____

GIR/GIP SIGNATURE: _____ DATE: _____

Give completed form to your GIR in your Benefits Office by November 14, 2008

BENEFIT CHOICE ELECTION FORM
INSTRUCTION SHEET

*If you are keeping your current coverage elections you do **not** need to complete this Benefit Choice Election Form*

SECTION A – EMPLOYEE INFORMATION (Complete all fields)

SECTION B – OPT OUT / OPT IN (This election applies to all coverage, except life coverage)
If you wish to opt out of the State Employees Group Insurance Program you must mark the 'Opt Out' box in Section B and submit the form, along with proof of other health coverage, to your agency/university Group Insurance Representative (GIR). The coverage must be provided by an entity other than Central Management Services.

SECTION C – HEALTH PLAN ELECTIONS
Do not complete this section if you only want to change your Primary Care Physician (PCP) – you must contact your managed care plan directly in order to make this change.

If you wish to change your **health** plan you must check either the Quality Care Health Plan (QCHP) or the managed care plan box. If **electing/changing managed care plans**, you must enter the managed care plan's carrier code (see map on page 13 for carrier codes), the plan's name and the provider identifier. The provider identifier is associated with a specific physician and is referenced as either the PCP code (6 characters) or NPI code (10 characters). Provider identifiers are located in the managed care plan's online directory, available on their website (see inside front cover of this booklet for website addresses).

SECTION D – DENTAL PLAN OPTION
- If you are currently participating in the **dental** plan and wish not to participate you must check the 'I choose not to participate in the dental plan' box (proof of other dental coverage is not required). If you elect not to participate, you can re-enroll **only** during a future Benefit Choice election period.
- If you **currently are not** participating in the **dental** plan and wish to enroll/re-enroll you must check the 'I choose to enroll/re-enroll in the dental plan' box. Benefit Choice is the only time you can enroll/re-enroll in the dental plan.

SECTION E – OPTIONAL LIFE INSURANCE
Complete this section if you wish to add/drop/increase or decrease Optional Life[1] or Accidental Death and Dismemberment (AD&D) coverage. **Note:** Optional Life Coverage subject to $3,000,000 maximum (basic + optional life). AD&D Combined maximum is 5 times the employee salary (basic plus 4 times optional coverage).

SECTION F – DEPENDENT INFORMATION
Complete this section if you are adding, dropping or changing your dependent health or life[1] coverage. If you are adding health or life dependent coverage, **you must provide the appropriate documentation as indicated below**:

Spouse	Marriage certificate
Natural Child through Age 18	Birth certificate
Stepchild	Birth certificate indicating your spouse is the child's parent, marriage certificate and proof the child resides with you at least 50% of the time.
Adopted Child	Adoption certificate stamped by the circuit clerk.
Adjudicated Child/Legal Guardian	Court documentation signed by a judge.
Student	Birth certificate, Dependent Coverage Certification Statement (CMS-138)*, and verification of full-time student enrollment in an accredited school.
Handicapped	Birth certificate, Dependent Coverage Certification Statement (CMS-138)*, and a letter from the doctor 1) detailing the dependent's limitations, capabilities and onset of condition from a cause originating prior to age 19 (age 23 if enrolled as a full-time student), 2) a diagnosis from a physician with an ICD-9 diagnosis code and 3) a statement from the Social Security Administration with the Social Security disability determination, along with a copy of the Medicare card.
* The Dependent Coverage Certification Statement (CMS-138) is available through your agency Group Insurance Representative (GIR) or online at **www.benefitschoice.il.gov**.	

[1] If you are applying to add or increase Optional Life, Spouse Life or Child Life, you must complete, sign and mail a Statement of Health application to ***Minnesota Life, 1 North Old Capitol Plaza, Suite 305, Springfield, IL 62701***. The application is available on page 33.

SIGNATURE: You must sign and date the Benefit Choice Options Period 2 Election Form and give to your agency GIR by **November 14, 2008** in order for your elections to be effective January 1, 2009. Dependent documentation must be submitted to your GIR within 10 days of the end of the Benefit Choice Period. **If documentation is not provided within the 10-day period, your dependents will not be added.**